

Exhibit K-1

Affidavit of

Geoffrey Negin, M.D. and C.V.

EXHIBIT K-1

AFFIDAVIT OF GEOFFREY A. NEGIN, M.D.

STATE OF FLORIDA

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COUNTY OF LEE

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BEFORE ME, the undersigned authority, on this day personally appeared Geoffrey A. Negin, M.D., known to me to be the person whose name is subscribed below and who being first duly sworn by me, according to the law, upon his oath deposed and stated as follows:

“My name is Geoffrey A. Negin, M.D., I am a resident of the state of Florida, above the age of eighteen (18) years, have never been convicted of a felony, am fully competent to make this Affidavit, and have personal knowledge of the facts set forth herein which are true and correct.

“I am a licensed physician in the state of Florida, specializing in Neuroradiology. I received my Bachelor of Art in Biology at Brandeis University in 1985. I received my Doctor of Medicine at the University of Miami School of Medicine in 1989. I completed my residency while attending the University of South Florida College of Medicine from 1989-1993. I attended a Neuroradiology Fellowship from 1993-1994.

“I am board certified in Diagnostic Radiology.

“I am a Senior member of the American Society of Neuroradiology and have a Certificate of Added Qualification (CAQ) in Neuroradiology.

“I have been featured in the Fort Meyers News Press weekly medical column. I have been on WINK News (Channel 2/NBC) for their quarterly medical news program. I have presented over 100 lectures on topics including Orthopedic MRI, MRI of brain/spine, MRI applications for internists, Detection and treatment of osteoporosis, PET scanning, Vertebroplasty procedures, and medical/legal implications of imaging. I have been presented with the Outstanding Research/Presentation Award, Resident’s Day, at the University of South Florida College of Medicine in 1992.

“A copy of my curriculum vitae is attached to this affidavit and is incorporated herein by reference.

“A radiologist is a medical doctor who specializes in diagnosing and treating injuries and diseases using medical imaging and tests such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET) and ultrasound.

These types of doctors complete at least 13 years of training, including medical school, a four-year residency, and most often, an additional one or two-year fellowship of very specialized training, such as radiation oncology, pediatric radiology, or interventional radiology. They are certified by the American Board of Radiology and have exacting requirements for continuing medical education throughout their years in practice.

“Radiology itself is a branch of medicine dedicated to the use of imaging technology to not only diagnose but also treat disease. There are two veins or branches: diagnostic and interventional. Interventional is the branch where the doctors specializing in this field diagnose and treat patients using image-guided, minimally invasive techniques such as X-rays and MRIs. They carefully guide instruments through tiny incisions in the body, reaching the source of a medical problem and delivering targeted treatments. These treatments are for conditions such as heart disease, stroke, cancer, and uterine fibroids, offering less risk, pain and recovery time compared to traditional surgery. Diagnostic radiology uses a variety of imaging procedures to see inside the body and assess or diagnose a patient’s condition. Usually, a treating or referring physician refers a patient to an expert consultant for radiologic imaging who then interprets and reports on the resulting images, recommending treatment and, only when appropriate, additional testing. Diagnostic radiologists may also specialize in various radiology subspecialties such as breast imaging, cardiovascular radiology (heart and circulatory system), and neuroradiology (brain and nervous system; head, neck and spine), to name a few.

“Radiologic imaging can be critical to the health care of an individual in not only diagnosing certain conditions, but also in disease management. Radiologic imaging uses the art and science of radiation to provide images of bones, organs, soft tissue and vessels that make up the human body. The images are then records on film or video that are then interpreted radiologist to diagnose disease, injury or congenital abnormality.

“I have been asked by The Willis Law Group to examine the following cases:

- **Patient A**
- **Patient B**
- **Patient C**
- **Patient D**

and provide my opinions regarding the radiologic imaging and reports of each claimant in the context of each claim or case that has been filed by each claimant. In doing so, I have reviewed the following materials:

- **Patient A**

Underlying Tort Complaint

Bill of Particulars

Medical Records, CitiMD, Radiology

Medical Records, Kolb Radiology

Medical Records, Merola, Andrew, Ortho

Medical Records, NY Ortho & Spine, Ortho

Medical Records, Palo PT & Rehab, Physical Therapy

Medical Records, Pula, Adrian RPT, Physical Therapy

Medical Records, Univ Ortho, Ortho

Medical Records, Urban Health Plan

Medical Records, Vista Med Rehab, Physical Therapy

Amended Verified Complaint

Claimant's Affidavit

Radiology Imaging, Kolb MRI - Cervical, Lumbar & Shoulder, Films Dated 5.14.20

- **Patient B**

Underlying Tort Complaint

Bill of Particulars, Bushwick

Bill of Particulars, Capital Concrete

Bill of Particulars, RYC Cleaning

Bill of Particulars, Sam Maintenance Service

Supplemental Bill of Particulars

Medical Records, Comprehensive Ortho & Spine

Medical Records, Elmhurst Hospital

Medical Records, Excell Clinical Lab

Medical Records, IME Ortho, Alvarez, Eduardo, 4.05.19

Medical Records, IME Ortho, Spataro, Anthony, 10.29.19

Medical Records, Kolb Radiology

Medical Records, Lenox Hill Radiology

Medical Records, McCulloch Orthopaedic Surgical
Medical Records, NY Ortho & Sports, Ortho
Medical Records, Pula, Adrian, RPT, Physical Therapy
Radiology Imaging, Elmhurst Hospital, 10/26/18, Left Knee X-Rays
Radiology Imaging, Elmhurst Hospital, 3/01/18, Left Knee X-Rays
Radiology Imaging, Elmhurst Hospital, 3/01/18, CT Cervical Spine
Radiology Imaging, Elmhurst Hospital, 3/01/18, Left Shoulder X-Rays
Radiology Imaging, Elmhurst Hospital, 7/27/17, Testicular Ultrasound
Radiology Imaging, Elmhurst Hospital, 7/27/17, CT Abdomen Pelvis
Radiology Imaging, Elmhurst Hospital, 11/22/16, Right Ankle X-Ray
Radiology Imaging, Kolb, 12/04/18, MRI Left Knee
Radiology Imaging, Kolb, 3/17/18, MRI Cervical Spine
Radiology Imaging, Lenox Hill, 11/28/20 MRI Right Ankle
Radiology Imaging, Lenox Hill, 3/03/20, MRI Cervical Spine
Radiology Imaging, Lenox Hill, 2/01/22, MRI Right Ankle
Radiology Imaging, Lenox Hill, 2/01/22, X-Ray Right Ankle

- **Patient C**

Underlying Tort Complaint
Bill of Particulars
Medical Records, CitiMD, Radiology
Medical Records, Jankowska, Preop Clearance
Medical Records, Kolb Radiology
Medical Records, Lenox Hill Radiology
Medical Records, Merola, Andrew, Ortho
Medical Records, NY Ortho & Spine, Ortho
Medical Records, Pula, Adrian, RPT, Physical Therapy
Medical Records, Westchester Medical Care, Neuro & Rehab
Medical Records, St. Barnabus Hospital

Radiology Imaging, St. Barnabus

Affidavit in Support of Default

Claimant Affidavit

Radiology Imaging – St. Barnabas Hospital

- **Patient D**

Underlying Tort Complaint

Amended Verified Complaint

Verified Bill of Particulars (T Silva)

Verified Bill of Particulars (Expo Concrete)

Medical Records, CitiMD

Medical Records, Comprehensive Ortho & Spine

Medical Records, IME D'Ambrosio, Philip 11.30.23

Medical Records, IME Ortho, Katz, Michael, 4.28.22

Medical Records, IME Ortho, Katz, Michael, 12.07.22

Medical Records IME Ortho, Katz, Michael, 12.07.22

Medical Records IME Ortho, Katz, Michael, 3.27.23

Medical Records, IME, Sass, Peter 1.18.22

Medical Records, IME, Sass, Peter 3.23.23

Medical Records, IME Ortho, Shein, Wei 1.18.22

Medical Records, IME Addendum Ortho, Shein, Wei 1.24.22

Medical Records, Kolb Radiology

Medical Records, Lenox Hill Radiology

Medical Records, NY Ortho & Spine

Medical Records, Physical Medicine & Rehab

Medical Records, St. Barnabus Hospital

Radiology Imaging, CitiMD

Radiology Imaging, Hudson Regional Medical Center

Radiology Imaging, Kolb Radiology

Radiology Imaging, NY Ortho

Radiology Imaging, St. Barnabus Hospital

Patient A.

“According to his case records, Patient A was injured on April 23, 2020, at 10 a.m. when he was struck by a falling piece of wood weighing about 70 lbs. to the left side of his body. According to the Bill of Particulars, as a result of this accident, he suffered injury to his L5-6, C5-6 and left rotator cuff. More specifically, it reflects an alleged diagnosis of C5-C6 radiculopathy; disc herniations at C4-5 and C5-6 with central and bilateral foraminal narrowing; post traumatic cervical pain with symptoms of cervical radiculopathy; bilateral lumbar radiculopathy; focal central posterior disc herniations at L5-S1 with central and bilateral foraminal narrowing; partial rotator cuff tear involving the supraspinatus and infraspinatus tendons with subdeltoid bursal effusion, left shoulder; post traumatic lumbar pain; fracture of the 11th and 12th ribs; post-traumatic dizziness in association with posterior head/neck pain dizziness likely cervicogenic in nature.

“According to the medical records provided to me, Patient A did not present to a facility until five (5) days after the accident when he went to Urban Health Plan. There is a note in his records that indicates he went to an emergency provider right after the accident, if this is true, I do not have these first records. Nevertheless, the Urban Health records reflect Patient A had no bruising but had tenderness at his chest wall. X-rays were unavailable due to COVID. On May 5, 2020, Patient A represented to Urban Health where again he had no bruising and no chest wall tenderness. On May 14, 2020, he presented to New York Ortho, Sports Medicine & Trauma where he, for the first time to my knowledge, complained of left shoulder, cervical and lumbar pain. No medical history was provided. An examination was performed and he was sent to Kolb for an MRI. On May 15, 2020, Kolb performed MRIs on the cervical and lumbar regions of Patient A. According to the cervical report, Patient A was found to have a C4-C5 herniation with no impingement on the thecal sac and narrowing and a C5-C6 herniation impinging on the thecal sac. C6-C7 were found to be within normal limits. On the lumbar report Patient A was found to have an L5-S1 herniation with no impingement on the thecal sac and narrowing and L1-L5 were found to be within normal limits.

“I have read both these MRIs. The cervical MRI of Patient A shows no herniations but does show a small bulge at C5-C6, indicating the images were misread. The report on the lumbar MRI of Patient A is correct. Neither indicates a real injury that can be, in all reasonable medical probability, causally related to the alleged accident as his imaging appears degenerative in nature.

“I defer to the opinions of an orthopedic surgeon or neurosurgeon unrelated to the underlying case for further explanation, determination if surgery is warranted, and causation analysis.

“I await further imaging and records to provide any further opinions on Patient A.

Patient B.

“According to his case records, Patient B was injured on February 8, 2018, at 11 a.m. when he fell from a ladder. However, further case records are inconsistent with this alleged fact scenario in the complaint and with each other. Other records, medical in nature, say Patient B was injured from falling off the third step of a ladder onto a steel beam, from falling from height, from tripping, from falling when one of the steps collapsed leaving him to fall six steps, falling off five-foot ladder, and falling from sixth step of a ladder. According to one Bill of Particulars, as a result of this accident, Patient B was allegedly diagnosed with disc herniation at C6-7 impinging upon the thecal sac and right lateral recess with narrowing of the neural foramina bilaterally, posterior disc herniation at C4-5 with central and right foraminal narrowing, post traumatic cervical pain with symptoms of cervical radiculopathy, left shoulder internal derangement, left shoulder pain, left knee pain, left knee sprain, and left knee contusion. According to others, he sustained the following injuries: internal derangement of the left knee, Parrot- Beak type tear medial meniscus, posterior horn of the left knee, radial tear of the lateral meniscus, left knee, articular surface injury of distal femur, articular surface and patellofemoral groove, left knee, partial tear of anterior cruciate ligament of left knee, severe synovitis, multiple compartments, left knee, having a left knee arthroscopy with partial medial and lateral meniscectomies, abrasion chondroplasty of distal femoral condyle articular surface, major synovectomy in multiple compartments, left knee, and disc herniation at c6-7 impinging upon the thecal sac and right lateral recess with narrowing of the neural foramina bilaterally, posterior disc herniation at C4-C5 with central and right foraminal narrowing, post traumatic cervical pain with symptoms of cervical radiculopathy, left shoulder internal derangement, left shoulder pain, left knee pain, left knee sprain, and left knee contusion.

“He continued to work for three weeks before seeing any medical provider. On March 1, 2018, he presented to Elmhurst Hospital for complaints of left shoulder pain and left knee pain. He was diagnosed with a contusion of the left knee, neck strain and injury to the left shoulder. Upon physical examination, his gait was steady. There was no previous medical history noted. While he demonstrated tenderness in the cervical area, his range of motion was within normal limits. There was no spine pain and no contusions. Neurologically, there was no loss of consciousness, no headache, no dizziness. Thoracic and lumbar regions within normal limits. While his knee and shoulder were tender, they were neurovascularly intact and within normal limits with no skin contusions. He had mild to moderate multilevel degenerative disc disease with no significant spinal canal or neuroforaminal stenosis. He was diagnosed ultimately with cervical and left shoulder strain and contusion of the left knee. On August 14, 2018, he complained of Otagia bilaterally at Elmhurst. There was no cervical complaints and his neuro examination was within normal limits. He represented on October 26, 2018, complaints of knee pain. X-rays were taken and were found to be within normal limits. He again went to this hospital on November 5,

2018 with the same complaints, this time using a walking device. Another X-ray was taken and was found to be within normal limits with the exception of a small effusion.

“Despite the Elmhurst findings, Patient B presented to New York Ortho on March 13, 2018 complaining of pain to his knee, shoulder, and neck. He was found within normal limits on X-ray with full range of motion in the shoulder on examination. He had a good rotator cuff. Interestingly, he was placed in a cervical collar and sent for an MRI. According to the MRI report from Kolb on March 17, 2018, Patient B suffered from a herniation at C4-C5 impinging on thecal sac with mild narrowing of the right neural foramen, a C6-C7 herniation impinging on thecal sac and right lateral recess with mild narrowing neural foramen bilaterally. He then went back to New York Ortho on April 17, 2018 for complaints about his shoulder. Then Patient B was diagnosed with “left shoulder derangement.” He was sent for physical therapy and ESI. Kolb performed an MRI of Patient B’s left knee on December 4, 2018, which report reflected Patient B had a flap tear of the peripheral inferior articular surface of the posterior horn and body of the medial meniscus, a posterior capsular disruption with a 3-centimeter popliteal cyst, a partial tear of the posterior tibial insertion of the medial collateral ligament, a 9-millimeter osteochondral defect in the anterior medial femoral condyles and joint effusion. He continued with New York Ortho, ESI, physical therapy, and more radiographs as time went on.

“On June 3, 2019, Patient B had a chest X-ray at East Side Primary which was reported as within normal limits. On March 3, 2020, he had another MRI of his cervical area at Lenox which report stated he had a disc bulging with a superimposed right posterolateral disc protrusion narrowing the right lateral recess at C6-C7, a posterior disc bulging deforming the thecal sac at C5-C6, a posterior disc bulge, greater to the right of midline, mildly deforming the thecal sac at C3-C4, and a straightening of the cervical lordosis.

“By July 27, 2020, the complaints to New York Ortho now included the ankle which had not been previously an issue. From this point forward, all efforts were concentrated on Patient B’s ankle while physical therapy concentrated on his cervical spine.

“On November 28, 2020, well over two years after the alleged accident, Patient B had an MRI taken of the ankle by Lenox which report reflected heterotopic ossification in the syndesmosis and in the region of the anterior inferior and posterior inferior tibiofibular ligament, thickening of the anterior talofibular ligament and calcaneofibular ligament consistent with partial thickness tear, an ossicle in the anterior talofibular ligament, thickening and edema of the deep fibers of the deltoid ligament consistent with partial tear of the deep fibers thickening of the superomedial portion of the spring ligament compatible with partial thickness tear, advanced arthropathy of the hindfoot and midfoot, peroneal tenosynovitis, insertional tendinosis of the posterior tibial tendon, medial and lateral subcutaneous edema which could reflect soft tissue contusion, moderate tibiotalar and subtalar joint effusion, and partial replacement of the sinus tarsi fat with edema. He was referred for surgery when on January 19, 2021, almost three years after the accident, Patient B was preoperatively seen by McCulloch. On February 19, 2021, Patient B underwent a surgery

to his right ankle for alleged right ankle internal derangement, right ankle joint effusion, right ankle partial tears of anterior talofibular ligament and calcaneofibular ligaments, right ankle avulsion fracture of distal fibula, right ankle tenosynovitis of peroneal tendons, right ankle tendinosis of posterior tibial tendon. He had osteoarthritis.

“On February 1, 2022, Patient B had an X-ray of his right ankle at Lenox which was compared to a previous MRI from 2020. The report stated there was no fracture or post fracture deformity, normal bone mineral density by X-ray technique, moderate to severe osteoarthritis of the tibiotalar and subtalar joints with remodeling of the articular surfaces, subchondral sclerosis, and marginal spurring, and ossification of the interosseous ligament distally. An MRI was then taken the same date of the ankle by Lenox which report reflected heterotopic ossification of the anterior inferior tibiofibular ligament and posterior inferior tibiofibular ligament, thickening of the interosseous ligaments consistent with scarring from partial tear, status post ATFL reconstruction, thickening of the anterior talofibular ligament consistent with scarring/granulation tissue, no fluid disruption is identified, the calcaneofibular ligament is intact, diffuse intermediate to high-grade cartilage loss throughout the tibiotalar joint with subchondral marrow edema with some remodeling and osteophytes formation at the joint margin, advanced cartilage loss with marrow edema cystic change at the second tarsal/metatarsal joint, low-grade plantar fasciitis, tendinosis/tenosynovitis of the inframalleolar segment of the posterior tibial tendon and tibiotalar and subtalar joint effusion.

“I have the radiologic imaging taken about six weeks after the incident on March 17, 2018 by Kolb which is an MRI of the cervical area. The MRI imaging is not accurately reflected in the MRI report. There are no herniations and mostly osteophytic activity causing a narrowing of the right foramen. Otherwise, the imaging is normal. Osteophytes are essentially bone spurring which is part of the natural degenerative process of the spine. Such is not causally related, in all reasonable medical probability, to the accident at issue. The MRI taken of Patient B’s right knee does reflect a tear in the medial meniscus with arthritis. However, one cannot say with any reasonable medical certainty, that such was not pre-existing or when such actually occurred. The MRI taken of Patient B’s cervical region the area of C6-C7 improved as the area at issue got smaller. The MRI taken of Patient B’s right ankle, three years after the accident demonstrates arthritis and inflammation of the tendon outside of the ankle. This is wholly unrelated to the accident in all reasonable medical probability. He had corrective surgery based on the medical records. A later X-ray demonstrates arthritis. Overall, while Patient B a few little issues, overall his condition improved.

I defer to the opinions of an orthopedic surgeon or neurosurgeon unrelated to the underlying case for further explanation, determination if surgery is warranted, and causation analysis.

“I await further imaging and records to provide any further opinions on Patient B.

Patient C.

“According to his case records, Patient C was injured on December 6, 2021, at 3 p.m. when he fell from an improperly secured elevated surface. However, further case records are somewhat inconsistent with this alleged fact scenario in the complaint and with each other. Other records, medical in nature, say Patient C was injured while disposing of construction debris, when he fell from the second floor hitting his shoulder and leg on the left side, and/or while holding a heavy trash can weighing 50 lbs. when he slipped and fell on his left side. According to the Bill of Particulars, as a result of this accident, he was allegedly diagnosed with a posterior disc bulge at C3-C4 impinging upon the thecal sac with narrowing the left-sided neural foramen, broad posterior disc herniation at C4-C5 impinging upon the thecal sac, posterior disc bulge at C6-C7 impinging upon the thecal sac, disc bulge at L4-L5 impinging upon the thecal sac, narrowing the inferior aspects of the neural foramina bilaterally, lumbar radiculopathy, cervical radiculopathy, intra substance tear of posterior horn medial meniscus, left knee, partial tear of the anterior cruciate ligament of the left knee, rotator cuff tear at the anterior supraspinatus musculotendinous junction, left shoulder, internal derangement with peripheral tear, left shoulder, internal derangement of left wrist, internal derangement of left ankle, head trauma, and antalgic gait.

“According to the medical records provided to me, Patient C first presented to St. Barnabas following the incident on December 6, 2021. According to these records, recorded immediately after the accident, he fell from the second floor hitting his shoulder and leg on the left side. He had no altered mental status, no confusion or vision issues, and a Glasgow Coma Scale of 15, which is normal. He complained of left shoulder pain and nothing else. His left shoulder was tested and found to have normal range of movement without pain. While there was tenderness to his left hip and knee, there were absolutely no abrasions noted. CT scans of Patient C’s brain and lumbar regions were taken and found to be within normal limits. X-rays were taken of his left knee, pelvis, and chest and were found to be within normal limits. Subtle fractures to the pelvis were discussed and the records state that a CT might be performed to rule out such fracture. To my knowledge, none was performed. He was discharged on Tylenol.

“Despite the foregoing findings, numerous MRIs were subsequently done by Kolb beginning December 22, 2021. The MRI of the lumbar spine taken December 22, 2021, according to the report, demonstrated a disc bulge at L4-5 impinging upon the thecal sac narrowing the inferior aspects of the neural foramina bilaterally with the rest being within normal limits. The MRI of the cervical spine taken December 22, 2021, according to the report, demonstrated a posterior disc herniation at C4-C5 impinging upon the thecal sac, and shallow posterior disc bulges at C3-C4 and C6-C7 with the rest being within normal limits. On January 3, 2022, MRIs were taken of Patient C’s knee and shoulder. Why this was not done previously when he was already at Kolb I do not know. Nevertheless, according to the knee report, there was a partial tear of the anterior cruciate ligament, with the posterior cruciate ligament being intact and small joint effusion. According to the shoulder report, there was a low-grade partial rotator cuff tear at the

anterior supraspinatus tendon at its musculotendinous junction. On November 1, 2022, less than a year later, MRIs were again taken of Patient C's cervical and lumbar spine. Why, I do not know as a year had not passed since the previous MRIs. The MRI of the lumbar spine, according to the report, demonstrated a disc bulge at L4-5 mildly impinging upon the thecal sac in the inferior aspects of the neural foramina bilaterally with the rest being within normal limits. The MRI of the cervical spine, according to the report, demonstrated a shallow posterior disc herniation at C4-C5 impinging upon the thecal sac, disc bulges at C3-C4 and C6-C7 with the rest being within normal limits. On January 3, 2022, another MRI was taken of Patient C's knee which report indicated he had an intra substance tear of the posterior horn medial meniscus requesting a clinical correlation and a partial tear of the anterior cruciate ligament and small joint effusion. Nerve conduction studies were also performed which stated Patient C had lumbar and cervical radiculopathy. On April 19, 2023, Patient C underwent "neuro rehabilitation" at Westchester where there is information, for the first time, that he had loss of consciousness, a headache, syncope and other issues leading to a "diagnosis" of traumatic brain injury. This is inconsistent with all other medical entries for his initial evaluation after the incident.

"I have reviewed the images from St. Barnabas and can confirm the imaging is consistent with the reports with minimal bulging occurring at L4-L5. There is nothing indicating at this time, based only these images, and the entries in the St. Barnabas medical records, that Patient C suffered an injury as a result of his alleged accident. Nothing indicates a real injury that can be causally related, in all reasonable medical probability, to the alleged accident as his imaging in my possession appears degenerative in nature.

"I defer to the opinions of an orthopedic surgeon and/or neurosurgeon unrelated to the underlying case for further explanation, determination if surgery is warranted, and causation analysis.

"I await further imaging and records to provide any further opinions on Patient C.

Patient D.

"According to his case records, Patient D was injured on October 29, 2021, when construction material "fell from above" striking him. Further case records indicate he was hit by a metal beam that fell from the third floor of a construction site. Other records, medical in nature, say he was injured when the beam fell and hit his right arm, another when he twisted, another when twisted while withdrawing, fell backward, fell forward, fell backward striking a pole and placing props. Such factual alleged actions are not consistent. According to the Bill of Particulars, as a result of this accident, he was allegedly diagnosed with a posterior disc bulge at C3-C4 impinging upon the thecal sac with narrowing the left-sided neural foramen, broad posterior disc herniation at C4-C5 impinging upon the thecal sac, posterior disc bulge at C6-C7 impinging upon the thecal sac, disc bulge at L4-L5 impinging upon the thecal sac, narrowing the inferior aspects of the neural foramina bilaterally, lumbar radiculopathy, cervical radiculopathy, intra substance tear of posterior

horn medial meniscus, left knee, partial tear of the anterior cruciate ligament of the left knee, rotator cuff tear at the anterior supraspinatus musculotendinous junction, left shoulder, internal derangement with peripheral tear, left shoulder, internal derangement of left wrist, internal derangement of left ankle, head trauma, and antalgic gait. He continued to work until November 30, 2021, about a month after his alleged disabling injuries.

“According to the medical records provided to me, there were numerous examinations and radiologic testing performed on various body parts of Patient D. On October 29, 2021, at St. Barnabas, he had an X-Ray of the right elbow which was within normal limits. According to these records, which are the first after the accident, he complained only of right arm pain and arrived by bus and was ambulatory. There was no medical history provided, no swelling, redness or head trauma. His neurologic exam was within normal limits. His cervical, thoracic and lumbar spine examination was within normal limits. He was alert, oriented x3, which is normal. Neurovascularly, he was intact with a power of 5/5. He was discharged on Tylenol and Motrin.

“Despite the foregoing findings which are essentially normal, on December 1, 2021, he underwent three cervical spine X-rays, two thoracic spine X-rays, three lumbar spine X-Rays and a CT of the thoracic spine for possible compression fracture, and an MRI was ordered at CitiMD. Some tenderness was noted on exam and the patient was not distressed and had a normal psych evaluation. By the 7th, he was referred to an orthopedic surgeon and to Kolb for radiologic imaging of the elbow. On December 16, 2021, Patient D had an MRI of his right elbow at Kolb which report stated there was a tear of the common flexor tendon with associated soft tissue edema. There was no such tear on the imaging. On the 20th of the same month, he underwent an MRI of the cervical spine at Kolb which report indicated he suffered from posterior disc herniations at C4-C5 and C6-C7 impinging upon the thecal sac, as well as a disc bulge at C3-C4. Why this was not done on the same day as the elbow is unclear. That same day, Patient D also underwent an MRI of the lumbar spine which, according to the report, showed shallow posterior disc herniations at L4-L5 and L5-S1 impinging upon the thecal sac and with narrowing of the inferior aspect of the left-sided neural foramina at both levels. That next month, on January 7, 2022, a cervical spinal X-ray revealed, according to the radiology report, unstable grade 1 retrolistheses of C4 upon C5 and C6 upon C6. That same day, an X-ray was also taken of Patient D’s lumbar spine. This, according to the report, revealed a minimal anterior marginal osteophyte formation at the superior endplates of L4 and L5. He was continuously “evaluated” by New York Ortho between doctors Kaplan and Grimm and was given physical therapy, nerve conduction studies, and medication including ESIs.

“On February 10, 2022, an MRI was performed again on Patient D’s lumbar spine at Lenox and, according to the report, revealed hemangioma in L4, mild diffuse facet hypertrophy at the facet joints, a straightening of the lumbar lordosis, a disc bulge with a left foraminal herniation at L4-L5, with a bilateral foraminal impingement more prominent on the left than on the right and anterior thecal sac impingement, a disc bulge associated bilateral S1 nerve roots at L5-S1 with a

left foraminal herniation with left foraminal impingement. An MRI of Patient D's right shoulder at Kolb which, per the report, showed a partial rotator cuff tear involving the supraspinatus and infra spinatus tendons extending to the distal insertion; tear of the anterior labrum extending into the inferior labrum. A comparison MRI of the cervical spine of Patient D was again conducted at Kolb on January 26, 2023 which allegedly showed disc herniations at C4-5 and C5-6 impinging upon the thecal sac with no interval change and a disc bulge at C3-4. A typographical error was corrected in an addendum dated March 6, 2023. A CT was conducted days later without explanation at Kolb which, according to the report, disc herniations at C4-C5 and C6-C7 impinging upon the thecal sac, a disc bulge at C3-C4, mild degenerative changes and a mild grade 1 retrolisthesis of C4 upon C5.

"On August 8, 2023, he underwent a cervical fusion by Dr. Weinstein at Hudson Regional Medical Center. Little was done post-operatively.

"Of those images that were available at the time of this report, I reviewed the MRI of Patient D's right elbow dated 12.16.21 from Kolb. Despite what is said in the Kolb report, there is not a demonstrative tear of the common flexor tendon of this claimant. Rather, the imaging shows thickening and tendonitis. This is, in all reasonable medical probability, pre-existing, especially in light of Patient D's employment as a laborer. The MRI taken of his lumbar spine demonstrates a bulge at L4-L5 but no herniations as indicated by the report. Such is degenerative in nature and not causally related to the accident at issue, in all reasonable medical probability. The MRI of Patient D's cervical spine is also incorrect, demonstrating a bulge at C4-C5 and no herniation. C5-C6 demonstrates arthritis which is degenerative. C6-7 does demonstrate a herniation, however. The lumbar spine X-rays do not reveal much. The MRI taken of Patient D's shoulder does not show a partial tear and appears to be a total fabrication of such injury. The imaging taken at CitiMD only really demonstrates arthritis and as indicated above, is degenerative and in all reasonable medical probability, pre-existing.


"I defer to the opinions of an orthopedic surgeon and/or neurosurgeon unrelated to the underlying case for further explanation, determination if surgery is warranted, and causation analysis.

"I await further imaging and records to provide any further opinions on Patient D.

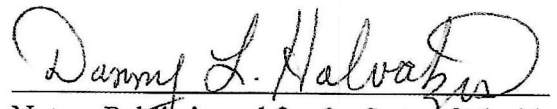
"It is not in my area of expertise to opine whether surgery was warranted in any of these instances and will leave such opinions to orthopedic surgeons and/or neurosurgeons unrelated to the underlying case. However, if surgery is being performed with incorrect radiologic reports that are inconsistent and in some instances, opposite to radiologic images, I find it hard to believe that surgery may be warranted. Of importance too, with regard to these claimants, many of the radiologic findings are degenerative in nature and wholly unrelated to the accidents alleged.

"I reserve the right to supplement and/or amend this Affidavit as additional materials become available to me for consideration.

"Further Affiant Sayeth Not."


GEOFFREY A. NEGIN, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME this the 28th day February 2024.


Notary Public in and for the State of Florida

Commission Expiration:



Geoffrey A. Negin, M.D.

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Fort Myers, FL 33908

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EDUCATION

University of South Florida College of Medicine, Tampa, Florida ■ 1993-1994
Neuroradiology Fellowship.

University of South Florida College of Medicine, Tampa, Florida ■ 1989-1993
Diagnostic Radiology Residency.

University of Miami School of Medicine, Miami, Florida ■ 1985-1989
M.D.

**** Alpha Omega Alpha, Phi Kappa Phi ****

Brandeis University, Waltham, Massachusetts ■ 1981-1985

B.A., Biology

**** Phi Beta Kappa, Magna Cum Laude ****

AWARDS AND COMMUNITY SERVICE

- Newspaper Column: Fort Myers News Press; weekly medical column
- Television Program: WINK News (Channel 2/NBC); quarterly medical news program
- Lectures: over 100 presentations on topics including Orthopedic MRI, MRI of brain/spine, MRI applications for internists, Detection and treatment of osteoporosis, PET scanning, Vertebroplasty procedures, Medical/legal implications of imaging
- Outstanding Research/Presentation Award, Resident's Day, University of South Florida College of Medicine, 1992

PROFESSIONAL EXPERIENCE

Florida Radiology Consultants, P.A., Fort Myers, Florida ■ 1994 – present

Director of Outpatient Imaging: 33-person radiology practice providing services for hospital and outpatient imaging. Performing general diagnostic and neuroradiology. Oversight of research, clinical trials, and imaging protocols.

Medical Director: Florida Neurology Group MRI; Orthopedic Specialists MRI; 21st Century Oncology PET/CT; SW Florida Urology CT

Preceptor: Kansas City University of Medicine and Biosciences College of Osteopathic Medicine & Nova Southeastern University College of Osteopathic Medicine

Expertise: Traumatic Brain Injury Assessment (including State of FL Death Penalty Evaluations and NFL Evaluations for CTE), Personal Injury/Forensic Evaluation, Medical Malpractice Evaluation, Neonatal HIE Evaluation and Child Abuse Evaluation

MEDICAL LICENSURE AND CERTIFICATION

Certificate of Added Qualification (CAQ) in Neuroradiology, active
American Board of Radiology, Board Certified in Diagnostic Radiology, active
American Society of Neuroradiology, Senior Member, active
Medical License, State of Florida, active

PUBLICATIONS AND PAPERS

- Vertebral Compression Fractures: Pain Reduction and Improvement in Functional Mobility after Percutaneous Polymethylmethacrylate Vertebroplasty; Radiology 2003
- CT-guided Needle Puncture of the Cervical Subarachnoid Space; AJR 1993
- Enhanced MRI in the Evaluation of Leptomeningeal and Spinal Cord Pathology; RSNA presentation 1992
- Pneumatic Reduction of Intussusception; University of South Florida College of Medicine 1991
- Efficacy of the ACBE in the Detection of Colonic Polyps: University of South Florida College of Medicine 1990

MEMBERSHIPS

American Society of Neuroradiology (ASNR)

Radiology Society of North America (RSNA)

American College of Radiology (ACR)

American Roentgen Ray Society (ARRS)

American Society of Spine Radiology (ASSR)

Lee County Medical Society

MENSA